CASE HISTORY FORM

Welcome to Chapman Chiropractic Center. We look forward to being part of your healthcare team. To help us serve you better, please provide the following information.

Personal Information

Name: _____ **DOB:** ____/_____/_____ **Gender** (circle): M F
(Legal First) (Middle Initial) (Legal Last)
Address:
_____
(Street) (City) (State) (Zip)

Home Phone Number: _____ **Cell Number:** _____ **Work Number:** _____
Is it ok to call you at work? O Yes O No

Relationship Status (circle one): Married/Single/Widowed/Divorced/Other

Social Security #: _____ - _____ - _____ **Height:** _____

Email:_____ **Weight:** _____

Employer Name: _____
Work Status (circle one): Employed/Student/Retired/Homemaker/Unemployed

Type of Work/Work Duties:_____
_____
Who may we thank for referring you to our office? O Family Member:_____
O Friend/Coworker:_____
O Phone Book O Web Search O Drive By/Live Close O Other:_____

Past Health Information

Previous (Event and Approximate Date): O Motor Vehicle Accidents_____
O Childhood Traumas_____ O Childhood Illnesses _____
O Sports Injuries _____ O Major Injuries/Falls _____
O Work Injuries _____O Emotional Traumas _____
O Broken Bones_____ O Cancer _____
O Stroke_____ O Major Strains/Sprains: _____
O Hospitalizations_____ O Other: _____

Major Surgeries/Operations: O Appendectomy O Tonsillectomy O Gall Bladder O C-Section O Hernia Repair O Hysterectomy
O Pace Maker O Back/Neck Surgery_____ O Joints Replaced_____ O Other: _____
_____

Family Health History (List Relationship): O Diabetes _____ O Cancer _____
O Heart Disease _____ O Stroke _____ O Thyroid _____
O Psychiatric _____ O Other:_____

Have You Had Previous Chiropractic Care? (__) No (__) Yes, please provide: Dr.'s Name: _____

Clinic Name/Location_____ Date of Last Visit _____ Reason for Visit: _____

Family/Primary Physician: Dr.'s Name: _____ Date of Last Visit**:** _____

Clinic Name/Location_____ Reason for Visit: _____

Vitamin/Supplement/Medication Name (Please Provide a list if available)	Amount Taken (mg)	How Long I've Been Taking It	Reason for Vitamin/Supplement/Medication

Lifestyle	Often	Occasionally	Never	In the Past
Smoke/use tobacco?	O	O	O	O
Drink alcohol?	O	O	O	O
Play adult sports?	O	O	O	O
Drink caffeine?	O	O	O	O
Computer/TV use?	O	O	O	O

Rate the following as Poor, Good, Excellent			
Diet:	Poor	Good	Excellent
Exercise:	Poor	Good	Excellent
Sleep:	Poor	Good	Excellent
Water Intake:	Poor	Good	Excellent

On a scale of 1 – 10, please describe your stress level over the past several months: (1 = None/10 = Extreme)

Occupational Stress _____ Personal Stress _____

Have you had trouble with any of the following?

Cardiovascular	**Current**	**Recent**	**No**
Poor Circulation	O	O	O
High Blood Pressure	O	O	O
Low Blood Pressure	O	O	O
Aortic Aneurysm	O	O	O
Heart Disease	O	O	O
Vascular Disease	O	O	O
Heart Attack	O	O	O
Chest Pain	O	O	O
Irregular Heartbeat	O	O	O
Swelling of Legs/Ankles	O	O	O

Genitourinary	**Current**	**Recent**	**No**
Kidney Disease	O	O	O
Lower Side Pain	O	O	O
Burning with Urination	O	O	O
Frequent Urination	O	O	O
Blood in Urine	O	O	O
Kidney Stone	O	O	O
Incontinence	O	O	O
Urinary Infection	O	O	O

Hematologic/Lymphatic	**Current**	**Recent**	**No**
Hepatitis	O	O	O
Blood Clots	O	O	O
Easy Bruising	O	O	O
Easy Bleeding	O	O	O
Fevers/Chills/Sweats	O	O	O

Respiratory	**Current**	**Recent**	**No**
Asthma	O	O	O
Shortness of Breath	O	O	O
Emphysema	O	O	O
Bronchitis	O	O	O
Cold/Flu	O	O	O
Persistent Cough	O	O	O

Ears/Nose/Throat	**Current**	**Recent**	**No**
Hearing Loss	O	O	O
Sinus Infection	O	O	O
Sore Throat	O	O	O
Difficult Swallowing	O	O	O
Bleeding Gums	O	O	O
Frequent Ear Infections	O	O	O

Eyes	**Current**	**Recent**	**No**
Glaucoma	O	O	O
Cataracts	O	O	O
Double Vision	O	O	O
Blurred Vision	O	O	O

Integumentary	**Current**	**Recent**	**No**
Skin Lesions/Rashes	O	O	O
Eczema	O	O	O
Psoriasis	O	O	O

Constitutional	**Current**	**Recent**	**No**
Weight Loss/Gain:_____ lbs.	O	O	O
Unexplained Fatigue	O	O	O
Difficulty Sleeping	O	O	O

Psychiatric	**Current**	**Recent**	**No**
Depression	O	O	O
Nervousness/Anxiety	O	O	O
Unusual Stress	O	O	O

Other: _____

Immunologic	**Current**	**Recent**	**No**
Immune Disorder	O	O	O
HIV/AIDS	O	O	O
Seasonal Allergies	O	O	O

Gastrointestinal	**Current**	**Recent**	**No**
Gallbladder Problems	O	O	O
Bowel Problems	O	O	O
Constipation	O	O	O
Diarrhea	O	O	O
Liver Problems	O	O	O
Ulcers	O	O	O
Nausea/Vomiting	O	O	O
Bloody Stools	O	O	O
Poor Appetite	O	O	O
Heartburn	O	O	O
Food Allergies: _____	O	O	O

Musculoskeletal	**Current**	**Recent**	**No**
Arthritis	O	O	O
Joint Stiffness	O	O	O
Muscle Weakness	O	O	O
Difficulty Walking	O	O	O
Osteoporosis/Bone Loss	O	O	O
Neck Pain	O	O	O
Back Pain	O	O	O
Jaw/TMJ Problems	O	O	O
Hip Pain/Stiffness	O	O	O
Scoliosis	O	O	O

Endocrine	**Current**	**Recent**	**No**
Hypothyroidism	O	O	O
Hyperthyroidism	O	O	O
Excessive Thirst	O	O	O
Hot Flashes	O	O	O

Neurological	**Current**	**Recent**	**No**
Dizziness/Vertigo	O	O	O
Seizures	O	O	O
Tremors	O	O	O
Head Injury	O	O	O
Headaches/Migraines	O	O	O
Fainting	O	O	O
ADHD/ADD/Autism	O	O	O
Pinched Nerves	O	O	O
Carpal Tunnel	O	O	O
Tingling/Numbness in arms/hands/fingers/legs/feet/toes	O	O	O

Reproductive	**Current**	**Recent**	**No**
Menstrual Pain	O	O	O
Menstrual Irregularity	O	O	O
Fertility Problems	O	O	O
Prostate Dysfunction	O	O	O
Sexual Dysfunction	O	O	O
Endometriosis	O	O	O
Polycystic Ovarian Syndrome	O	O	O

FEMALES ONLY:

Date of your last period? _____

Are you or is there a possibility that you are pregnant?

O Yes O No

Are you trying to become pregnant? O Yes O No

Please tell us what brought you into our office today: (check one)

O Wellness Care: please skip to the next page.
O Health challenge/symptom: please provide details below
O Injury: please provide details below

HEALTH CHALLENGE/SYMPTOM #1

Please describe your primary health challenge/symptom: _____
_____

What accidents/events/activities do you think are the cause? _____
_____

When did it start? # Days ago_____ # Weeks ago_____ # Months ago_____ # Years ago_____

What makes it better? _____
What makes it worse? _____

How would you describe the amount of time that you experience the health challenge/symptom? Please circle one.

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Achy/ Burning/ Cramping/ Dull/ Numbness/ Sharp/ Shooting/ Stabbing/ Stiffness/ Swelling/ Throbbing/ Tingling

Location of any numbness/tingling/radiating symptoms: _____
_____

Severity of Discomfort (0 = No Discomfort, 10 = Severe Discomfort): 0 1 2 3 4 5 6 7 8 9 10

List any daily activities/functions that are limited or difficult because of the symptom.
Please be as specific as you can. (i.e.: concentration, working, sleeping, sitting, standing, bending, lifting)
_____
_____
_____

☐ HEALTH CHALLENGE/SYMPTOM #2 (If Applicable):

Please describe your secondary health challenge/symptom: _____
_____

What accidents/events/activities do you think are the cause? _____
_____

When did it start? # Days ago_____ # Weeks ago_____ # Months ago_____ # Years ago_____

What makes it better? _____
What makes it worse? _____

How would you describe the amount of time that you experience the health challenge/symptom? Please circle one.

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Achy/ Burning/ Cramping/ Dull/ Numbness/ Sharp/ Shooting/ Stabbing/ Stiffness/ Swelling/ Throbbing/ Tingling

Location of any numbness/tingling/radiating symptoms: _____
_____

Severity of Discomfort (0 = No Discomfort, 10 = Severe Discomfort): 0 1 2 3 4 5 6 7 8 9 10

List any daily activities/functions that are limited or difficult because of the symptom.
Please be as specific as you can. (i.e.: concentration, working, sleeping, sitting, standing, bending, lifting)
_____
_____
_____

☐ Please list/circle any other health challenges/symptoms not listed above:

_____

JAW/ TMJ (L/R) RIB (L/R) SHOULDER (L/R) ELBOW (L/R) WRIST (L/R) HIP (L/R) KNEE (L/R) ANKLE (L/R)

_____
_____
_____
_____

Have you been evaluated by another healthcare professional for any of the above-listed health challenges/symptoms?
(__) No (__) Yes If yes, please provide the following information:

Name: _____

Clinic/Hospital Name and Location_____
Reason for Visit: _____ Date of Last Visit:_____

Name: _____

Clinic/Hospital Name and Location_____
Reason for Visit: _____ Date of Last Visit:_____

Have you had any MRI/CT or XRAY Studies performed?
(___) No (___) Yes If yes, please provide the following information:

Date: _____
Clinic/Hospital Name and Location:_____
_____

Date: _____
Clinic/Hospital Name and Location:_____
_____

OVERALL HEALTH ASSESSMENT:

1) How would you rate your current health status: (circle one) Excellent Good Average Poor

2) Where would you like your health to be? (circle one) Excellent Good Average Poor

3) Are any of the health challenges/symptoms you described preventing you from doing any activities that you need to do or want to do? Please explain in detail:
_____
_____

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**